# Conceptions about the relationships of care between workers and the person in crisis in a psychosocial care center

# Concepções acerca das relações de cuidado entre trabalhadores e a pessoa em crise em um centro de atenção psicossocial

# Concepciones sobre las relaciones de cuidado entre los trabajadores y la persona en crisis en un centro de atención psicossocial

*Franciele Savian Batistella[1], Leandro Barbosa de Pinho[2], Marcio Wagner Camatta[3], Rosemarie Gartner Tschiedel[4], Míriam Thais Guterres Dias[5]*

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1. Federal University of Rio Grande do Sul. Porto Alegre, Rio Grande do Sul. Brazil.
https://orcid.org/0000-0002-3446-8264

2. Federal University of Rio Grande do Sul. Porto Alegre, Rio Grande do Sul. Brazil.
https://orcid.org/0000-0003-1434-3058

3. Federal University of Rio Grande do Sul. Porto Alegre, Rio Grande do Sul. Brazil.
https://orcid.org/0000-0002-4067-526X

4. Federal University of Rio Grande do Sul. Porto Alegre, Rio Grande do Sul. Brazil..
https://orcid.org/0000-0002-3490-2120

5. Federal University of Rio Grande do Sul. Porto Alegre, Rio Grande do Sul. Brazil.
https://orcid.org/0000-0002-3881-4961

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**RESUMO**

**Objetivo:** analisar as concepções dos trabalhadores nas relações de cuidado estabelecidas com a pessoa em crise em um Centro de Atenção Psicossocial. **Método:** Trata-se de um estudo qualitativo, que teve como referencial teórico o materialismo dialético. Para produzir os dados foram utilizadas técnicas de observação participante, uma roda de conversa com a equipe de um centro de atenção psicossocial em Porto Alegre- RS e entrevistas individuais semi-estruturadas com os trabalhadores no período de outubro a dezembro de 2018. Resultados: as concepções de crise estão subjetivadas pelas vivências e experiências de cada trabalhador. Assim, as práticas em saúde mental situam-se numa relação intercessora e pendular entre o modelo psiquiátrico-hospitalocêntrico-medicalizador e o modelo psicossocial, operando em processos e movimentos contraditórios. **Conclusão**: as concepções do cuidado à pe?;l fcxzssoa em crise são individuais de cada trabalhador, sendo a relação pendular uma característica marcante desse cuidado.

**Descritores:** Saúde mental; Reforma psiquiátrica; Crise; Psicossocial.

**ABSTRACT**

**Objective:** to analyze the conceptions of workers in the care relationships established with the person in crisis in a Psychosocial Care Center. **Method**: this is a qualitative study, which had dialectical materialism as its theoretical framework. To produce the data, participant observation techniques were used, a conversation with the team of a psychosocial care center in Porto Alegre-RS and individual semi-structured interviews with workers from October to December 2018. **Results:** conceptions of crisis are subjectivized by the experiences of each worker. Thus, mental health practices are situated in an intercessory and pendular relationship between the psychiatric-hospital-centric-medicalizing model and the psychosocial model operating in contradictory processes and movements. **Conclusion**: the conceptions of care for people in crisis are individual to each worker, with the commuting relationship being a striking characteristic of this care.

**Descriptors:** Mental health; Psychiatric reform; Crisis; Psychosocial.

**RESUMEN**

**Objetivo:** analizar las concepciones de los trabajadores en las relaciones de cuidado establecidas con la persona en crisis en un Centro de Atención Psicosocial. **Método:** se trata de un estudio cualitativo, que tuvo como marco teórico el materialismo dialéctico. Para producir los datos se utilizaron técnicas de observación participante, conversación con el equipo de un centro de atención psicosocial de Porto Alegre-RS y entrevistas individuales semiestructuradas con trabajadores de octubre a diciembre de 2018. **Resultados:** las concepciones de la crisis están subjetivizadas por las experiencias de cada trabajador. Así, las prácticas de salud mental se sitúan en una relación intercesora y pendular entre el modelo psiquiátrico-hospitalizador-medicalizante y el modelo psicosocial operando en procesos y movimientos contradictorios. **Conclusión:** las concepciones de atención a las personas en crisis son individuales para cada trabajador, siendo la relación de desplazamiento una característica llamativa de esta atención.

**Descriptores:** Salud mental; Reforma psiquiátrica; Crisis; Psicosocial.

ORIGINAL

## Introduction

The process of the Brazilian Psychiatric Reform aims to broaden the conception of care for people in suffering, previously centered only on the psychiatric hospital, to a network of sanitary, territorial and sociocultural services and devices. It encompasses a perspective of care in freedom, privileging people's stories and life choices. It is known, however, that despite the advances in this process, numerous challenges have also arisen for the implementation of public policies and the Psychiatric Reform in the daily routine of health services and society itself.

Amarante[1] states that the process of the Brazilian Psychiatric Reform is complex and includes four fundamental fields/dimensions: the theoretical-conceptual, the technical-assistance, the legal-political and the socio-cultural. Thus, the changes proposed in these various dimensions are configured as a new paradigm of mental health care, where care for people who need mental health care implies the production of ethical-political practices and postures that have respect and co-responsibility for therapeutic practices as their guiding axis.

This new configuration of mental health practices, based on the process of the Psychiatric Reform and the anti-asylum movement, has allowed, in this sense, processes of overcoming the medicalizing hospital-centered psychiatric paradigm.[2] By itself, this conception attributes new ways of understanding and relating to madness, enabling the effectiveness of the Psychosocial Care model.

According to Costa-Rosa,[2] Psychosocial Care has been characterized by a set of practices whose theoretical-technical and ethical-political framework moves towards the paradigmatic overcoming of asylum psychiatry, "representing the sedimentation of a vast set of theoretical-technical and ethical variations, more or less radical, as the case may be, in relation to current and dominant practices". These paradigmatic changes have enabled a series of transformations in the field of mental health care, to overcome the Psychiatric Reform as a strict reform of psychiatry.

From this perspective, as pointed out by Amarante[3] and Dimenstein[4], care for people in crisis has been one of the most conflicting, intriguing and strategic issues for the Brazilian Psychiatric Reform, and is also one of the most complex points in the process of paradigmatic changes involving the restructuring of mental health care in Brazil. Souza[5] says that "the crisis shows impure and unavoidable madness", announcing "the harbinger of crime and the rupture of order".

Thus, the manifestations of the crisis, with all the issues it confronts and raises, often end up, according to the author, justifying the person's entry into the psychiatric circuit, in the context that we now call the psychiatric paradigm, characterized mainly by the silencing of these manifestations through isolation, mechanical and chemical containment, in addition to different forms of exclusion and segregation from the social space. These and other considerations are also pointed out in other studies.[6,7]

Antunes[8] states that certain work processes in the field of mental health still maintain crystallized practices of tutelage, blaming and exclusion of madness, typical of the asylum model.

Thus, based on these aspects, advances in relation to the understanding and modes of care from the psychosocial perspective were produced and are produced from contradictory processes, aspects and elements that coexist and cross care practices[9].

In this context, even community services, such as CAPS, which intend, in their matrix, to overcome/deconstruct asylum practices, can reproduce them when they still maintain a logic of care around the psychiatric hospital, carrying out specialized, fragmented, non-coordinated and impervious actions.[10]

Based on these aspects, it is considered important to bring a critical reflection on the issues related to these care services, which are a fundamental and strategic axis to think about care for people in crisis from a perspective of psychosocial care. Thus, the objective of this article is to analyze the conceptions of the workers of a Psychosocial Care Center (CAPS), based on the care relationships established in the service with people in crisis situations.

## Method

This is a qualitative, descriptive research, of the case study type. To achieve the proposed objectives, the dialectical approach method was used from a materialist perspective, based on a Marxist rereading. The dialectical approach, in this perspective, offers the possibility of understanding the movement of the practice of these workers, never in a finished or static way, but always in movement and transformation.[11]

The Marxist dialectical materialist method presupposes, in this sense, an analysis of reality that seeks to apprehend the set of internal connections of the thing, its aspects, its own development and movement,[11] based on the understanding of the different social elements interconnected to the same totality, respecting the historicity and contradictions contained in this process. For the description of this research, the following scientific writing instruments were used: COREQ and SRQR.

The study was carried out in a CAPS in a health district in the municipality of Porto Alegre, Rio Grande do Sul State, Brazil, from October to December 2018. The participants of the research were 11 workers from a CAPS. In order for this research to be effective and agreed, the project was sent for consideration by the CAPS team and the Municipal Health Department, in which a letter of consent was signed authorizing the research to be carried out in the service.

To experience the processes in the research field and produce the data, initially, contact was made with the CAPS team to carry out a first conversation movement with the study participants, presenting the proposal and making the agreements, which could be modified and revised throughout the research process.

Data production was carried out in two stages. In the first stage, a conversation circle was scheduled with the service workers at the CAPS itself on a team meeting day, with those who agreed to participate, in order to answer the following guiding question: what do you understand by crisis?

In this conversation circle, 11 workers participated, identified in the research with the acronym RCT which means "worker conversation circle", followed by the order in which they appear in the interview. Example: RCT01, RCT08. The objective of the conversation circle was to produce approximations

between the researchers and the field of research, as well as to debate with the workers their conceptions about the mental health crisis.

The conversation circle lasted 1 hour and 30 minutes and was recorded and transcribed in full. Once the first stage of data production was concluded, the second stage was carried out, which consisted of the application of individual and semi-structured interviews on the theme of Care for people in crisis at the CAPS.

Individual interviews were conducted with six CAPS workers based on a semi-structured script, to highlight their voice in relation to the theme and the object of study. For this moment, a tape recorder was used. The interviews were transcribed and analyzed. The workers interviewed individually were identified with code names (T01, T02, T03, T04, T05, T06), to maintain the confidentiality of personal information. The acronym RC was added to the record of each worker, so that worker T01 was identified as RCT01 for the conversation circle, and so on.

Two psychologists, two occupational therapists, three psychiatrists, one nurse, two nursing technicians and a security guard participated in the research. In these moments of data production, the objectives of the research and the ethical aspects involving the participation of the participants and the researcher's commitments were explained. After experiencing the processes in the field of study and the production of data, based on the research instruments, the thematic analysis of the interviews was carried out[12].

The thematic analysis consists of three stages: pre-analysis; exploration of the material and treatment of the results obtained and Interpretation. The pre-analysis stage comprises the floating reading, constitution of the corpus and the formulation and reformulation of the assumptions. For the floating reading, it was necessary to have direct and intense contact with the material produced, a moment in which relationships emerged between the initial assumptions, the emerging hypotheses and the theories related to the theme.

According to Minayo[12], during the stage of exploring the material, the researcher seeks to find categories that are meaningful expressions or words according to which the content of a speech will be organized. Categorization consists of a process of reducing the text to meaningful words and expressions. From there, inferences are proposed, and interpretations are made, interrelating them with the theoretical framework initially designed or opening other clues around new theoretical and interpretative dimensions, suggested by the reading of the material[12].

After the analysis was written, a new conversation circle was held with the workers in December, to show the results of the study and so that they could give feedback on what was found, factors that were taken into account in the final writing of the work.

This study complied with all the ethical precepts established by Resolution 466/2012 of the National Health Council of the Ministry of Health, which regulates ethics in research with human beings[13] and Resolution 510/2016[14], which deals with the ethical specificities of research in the human and social sciences, and others that use methodologies specific to these areas, as well as the ethical principles established by Resolution 311/2007 of the Federal Council of Nursing.[15]

It was submitted to the Research Ethics Committee (REC) of the proposing institution and to the Committee of the Municipal Health

Department, both of which were approved on August 25, 2018 and August 30, 2018, respectively, both under opinion no. 2854993. The participants signed the Informed Consent Form for the production of the interviews, in which the researchers committed to preserving the privacy of the participants and the confidentiality of the information produced. The term was signed by the participants in two copies.

## Results

Based on the interviews and the field experience, it was possible to observe that the CAPS occupies a preventive place in relation to the crisis and the mental health emergency, or on-call, as the workers usually call it in the service under study; it assumes the place where the person in crisis is most often referred:

*But it's all the result of management too, right? Most of the time. When they are already in crisis, they go to the shift, we send them straight to the shift, we see, manage them now, send them to the shift. Or when it comes in a lot, like that, it arrives well... If it goes into crisis, it is for management reasons. In its vast majority, from what I saw, right? So I think we prevent the crisis, actually. (S05, 2018).*

*There have been a few times that after a service here, sometimes it is not even a specific service from the doctor, another space, which evolved into a consultation and then we have to refer to an emergency, if necessary, then we call the family member and refer him to the emergency, to make an assessment, to hospitalize, If we think there is a risk, right? (S02, 2018).*

In this sense, it is perceived that one of the challenges of the CAPS is in the care relationship that is established when the person is already in crisis, because in addition to the existence of some limitations in the service, such as the lack of a physical structure that safely enables the management of the person in crisis, there is also a way of functioning within the structure of the service that does not support this care in an integral way:

> *That completely disorganized, psychotic patient in an outbreak, [goes to the shift]. We have no way to serve him here, there is no team, there is no material, anyway. (S05, 2018).*

The focus of the CAPS workers is on the management and the way they will approach care. The team is organized based on the conception of crisis as a set of symptoms, within a psychiatric framework. In this way, the team is oriented to avoid, circumvent or contain the onset of the crisis, within a medical and clinical perspective of the process:

> *We try to contain it [the crisis], as far as possible, chemically, in the sense that if there is psychomotor agitation, then we have to try mechanical containment and chemical containment. Because here in the service you can't have many injectable medications for a crisis, right? Although we even have some pharmacological resources, but no one wants to be put at risk or risk to third parties, right? So, like, it hardly happens, because I think that the crisis comes from management, you have to avoid the crisis and we realize it. (S05, 2018).*

> *Here at CAPS, we never needed to medicate anyone or contain it, we always managed to organize it in a more peaceful way. If we need to, we'll have to do it, but we've never done it, it's never been necessary. (S02, 2018).*

> *I have never experienced a crisis here at CAPS. We can always get around everything. Sometimes, there are slightly more intense crises, but, as I told you, sometimes it's the family, it's the lack of understanding, so we can address this. (S03, 2018).*

While workers circumvent the crisis to avoid it, there is an ethical dimension to this care that bets on tools and strategies based on listening, affection and bonding. The workers acquired a tranquility to deal with these issues, respecting the space and time of the service and the user himself. In the words of the workers:

> *Management, in this case [of the crisis], we would use management. Not only the medication, I think it's a set. (Q03, 2018)*
> *So in the management of the crisis, it is no different. They don't work out. Things don't explode here, there isn't, like, a break, there isn't, because things are dealt with in their time and with the crisis as well. (S04, 2018).*

It is observed, through the field experiences, that there is a rhythm in the management among the team; The workers are in tune and aligned in the care proposal they have built over the years of work. In this aspect, it is perceived that, at the same time that this produces a healthy relationship for the team in the sense of having obtained constancy and uniformity in the practices, it also makes some contradictions and contradictory processes of the practice able to be apprehended in this care by the workers.

It is possible to perceive a consonance between the team's conceptions of crisis and the management undertaken, at the same time that there is a personal relationship between therapist-patient, worker-user and caregiver-caregiver, that is, there is a subjective relationship that is permeated by the sensations and impressions that the crisis produces in each one in this relationship.

The conceptions of crisis of the CAPS workers under study are subjectivized by the experiences of each worker. In general, there is agreement that the "crisis" does not occur spontaneously, from one moment to the next, but is part of a process that can be foreseen by an "enunciation" of signs. These signs are identified based on the conceptions of crisis of each worker, although there is a similarity/harmony of the team in the conception of crisis. Thus, it is understood by the researched team as a process of exacerbation of the mental disorder, a moment of greater intensity, of changes in behavior, in which the user needs to be assisted more closely and with greater agility.

> *From a medical point of view, so if we think about it from a clinical, clinical psychiatric point of view, a crisis is a moment of psychic suffering, where the person is disorganized. We work a lot here with psychotics. And/or you can also say that the person may be in crisis in a panic disorder, anxiety crisis. (S05, 2018).*
> *When I think of a crisis, I end up referring to my professional practice, I think of a crisis in a patient with a psychotic crisis, with a suicide risk picture, I think of a medical-psychiatric crisis, right? (RCT07, 2018).*

It is evident that the crisis, in addition to being a singular situation, that is, experienced in different ways, from each worker in the team, is also subjectivized by the conceptions of each professional nucleus. In this way, the management undertaken by the team is crossed/fed back by these individual and collective conceptions and perceptions. In this context, the perception that a crisis is "coming" is also related to the way and manner in which the worker feels about the person in crisis and the given situation.

> *Only the management, like, simpler, I don't think it's a crisis. I don't think this minor thing is a crisis, because I can handle it. I think it would be a crisis even if I couldn't manage it too, you know? (S03, 2018).*
> *I keep thinking that, because I was defining crisis from a medical point of view like this and now hearing you talk, I think it's a thing of feeling powerful or powerless to act on that situation. (RCT07).*

The worker T04 leads us to a perception of the crisis as something that leaves the person in pieces, that fragments, fades and refers to the difficulty in working with these situations, in which it is necessary to reconstruct and structure something that is presented in pieces, where the meaning and meaning of suffering are not yet elaborated. From this, it is also possible to visualize movements of recomposition of the "worker-self" in the experience of the care process.

> *Because during the crisis, the idea is that we can, like this, salute, gather a few pieces. [...] sometimes, the ICU is for the family member, for those who are accompanying the patient and not for the patient himself, because we don't tolerate that there. (S04, 2018).*

It is observed that psychiatric hospitalization is one of the aspects that contradict the practice and the relationship of the CAPS with the subject in crisis, because while a person in suffering is identified when he or she is in crisis, in need of care, the workers also suffer and are disorganized by this situation.

> *So I think that, sometimes, we also think about hospitalization for that, because it's tense, it's a very intense existential experience, including for those who are next door, right? [...] Maybe, sometimes, I suffer much more than the person, I suffer from that disorganization, that psychotic time zone makes me sick, because I have to follow along there, that, maybe, disorganizes me. (S04, 2018).*

The issue of hospitalization still appears as an alternative to overcome the crisis, being, in many moments, the most used resource of the network in the care of people in crisis. One of the questions is whether this hospitalization would be a real need of the person in crisis and/or becomes a strategy used by workers when they find a situation in which the ordering of the service, the tools they have and the user's support network are not enough.

It is perceived that, in some situations, the relationship established with the person in crisis can direct the trend of the care model, as evidenced by one of the workers:

*You are already beginning to see that, depending on the management, things will move one way or the other. (S05, 2018).*

It refers to the issue of countertransference in care and the importance of being aware of this in this relationship, inserting medication in a relational process between those who prescribe it and those for whom it is prescribed.

> *You keep thinking that the patient is getting worse, getting worse, medicating, increasing medication, increasing medication, when the issue is not in the medication, the issue is in the patient/therapist relationship. (S05, 2018).*

In view of this, it is perceived that drug treatment still assumes a centrality in the process of care for the person in crisis, and can assume a double role when used both as a device for significant improvement of the crisis with therapeutic effects and quality of life, and as a chemical containment that can cause, at times, more sedative effects. in order to cease the user's crisis, losing the opportunity to glimpse, in the crisis experienced by the user, effective

intervention possibilities that are not only located in the use of medication and/or a possible hospitalization.

Thus, the care practices for people in crisis at the CAPS are situated in an intercessory and pendulum relationship between the psychiatric-hospital-centered-medicalizing model and the psychosocial model, which operate in contradictory processes and movements and, from these relationships, mosaics of care are produced, enabling new configurations and ways of caring.

## Discussion

Resignifying care for people in crisis beyond the silencing of symptoms and isolation of the subject includes dealing with complexity and uncertainty, which directly impacts the ability of professionals and services to make themselves available to act in networks that replace the asylum model, reorganizing their work processes and articulating their practices.[16]

Thus, in order to think about the care relationships in the CAPS, it is necessary to highlight the clinical-political interface of mental health work, since these services imply other modes of creation that cannot be carried out without risking an experience of criticism and analysis of the instituted forms, which necessarily compromises us, with politics.[17] Thus, the need to invest in new forms of care that have a directional axis to the expanded clinic is highlighted, contributing to a new understanding of the health-suffering-psychic illness process, as well as to the invention of care practices.[18]

Franco[19] states that health work takes place from encounters between workers and between them and users, in permanent flows between subjects that are operative, political, communicational, symbolic, subjective and form an intricate network of relationships from which the products related to care gain materiality.

According to Ferigato, Campos and Ballarin[20], many professionals forget the intrinsic power of a crisis that offers an opportunity for transformation and deviation, "a moment of metamorphosis, of leaving a historically given place for another place to be simply reconstructed, due to its unprecedented character". In this way, it is necessary to question some conceptions that still exist in our daily lives that tend to generalize the crisis, understanding it as a deviation from normal conduct, as a mistake, as a difficulty in adaptation or disorder, thus seeking to construct ways of understanding crisis situations in their singularity and in their existential context.[21]

According to Merhy[22], in a crisis situation, the professional needs to use his clinic and perspicacity to welcome, listen, expose himself to transferential bonds and games, generate singular interventions and take advantage of the opportunity that the crisis offers to resignify the user's therapeutic project.

Fagundes[23] helps to think of mental health practice as a process that constructs social subjects that trigger transformations in the ways of thinking, feeling and making policies in everyday life, enabling other mediations capable of contributing to the creation of life projects.

There is a tenuous limit between producing autonomy or dependence, between caring or tutelage and these discussions need to be present in the work process of the professionals who work in CAPS and this presupposes a look beyond the "disease, which is articulated with the needs that people demand from the service."[24]

It is understood that the crisis situations of the person who uses the CAPS are not isolated facts, belonging only to the individual and restricted to a set of symptoms related to the disease or mental disorder, agreeing with the assumption that the problem is not the crisis itself, but the type of relationship that is established with the person who experiences it.

Similarly, it is proposed to look at crisis situations as the "birds that come to hit their beaks on the window glass"[25] provoking us to think about processes, situate trajectories, build alternatives and ways of overcoming the already instituted formats of dealing with madness, making it possible to understand the crisis as a situation experienced by a person, with rights, possibilities of choice and in a legitimate condition of existence.

## Final Considerations

It was possible to observe, from the study, that there is a reproduction and naturalization of a logic of care for the person in crisis that sees medication, psychiatric hospitalization and emergency care as more agile and problem-solving actions, often limiting the care of the person in crisis in the CAPS itself.

It was identified that workers, in the process of caring for people in crisis, are also affected by these situations, at the same time that the movements and processes of recomposition of the worker-self make it possible to transform the work relations and processes based on these encounters. In addition, we see that the relationship that is established with the person in crisis in the service can often direct care and re-situate the user's trajectories and care circuits.

Thus, it was observed that the conceptions of care for people in crisis are individual to each worker, and the pendulum relationship between the medical-hospital-centered-medicalizing model and the psychosocial model is a striking characteristic of this care. In addition, the crisis is configured in a singular situation, experienced in different ways from each worker in the team and subjectivized by the conceptions of each professional nucleus.

It is important to emphasize that the suffering and/or disorder of the person who experiences the crisis requires the use of traditional psychiatric schemes, and is also based on another ethics of care. This means betting on the possibility of other forms and other modes of relationship, which follow the therapeutic paths "together" with the user and that are capable of overcoming the logics of care that have pre-defined, protocol schemes and that always know what is best for the body and life of the other. Thus, the need to constitute ourselves, mental health professionals, as ethical and active subjects in the process of Psychiatric Reform is identified.

It is considered that the result of this research will bring contributions to the work process in the Care of people in crisis at CAPS II, enabling greater visibility of the work carried out in the CAPS experience, in Rio Grande do Sul, encompassing the challenges, contradictions and possibilities experienced by its workers in the Care of people in crisis, as well as for the strengthening of care practices in the field of Psychosocial Care.

It is understood that the study has limitations in terms of having only the conception of the service workers and not that of the users, in addition to the main source of data were semi-structured interviews and participant observation. It is considered that the use of more sources could bring more elements to the analysis of the object of study.

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**Autor de correspondência**
Franciele Savian Batistella
Universidade Federal do Rio Grande do Sul
Av. Paulo Gama, nº 110. CEP: 90060-040 – Farroupilha.
Porto Alegre, Rio Grande do Sul, Brasil.
fransavian@gmail.com